


Department of Employee Trust Funds
801 W. Badger Road
PO Box 7931
Madison WI 53707-7931

GROUP LIFE INSURANCE COLLECTION REPORT

Wis. Stat. § 40.06

Employer Name	Coverage Month	Employer No. 69-036-
---------------	----------------	-------------------------

	Coverage Type	Employee Deductions	% State Contributions	State Share
ALL STATE EMPLOYEES	Basic		x 63% =	
	50% Supplemental		x 35% =	
	100% Supplemental		x 35% =	
	Spouse & Dependent Children			
	Additional			
	Age 70 & Over			
TOTALS		(1)		(2)
		TOTAL REMITTANCE	(1 + 2)	

CASH COLLECTIONS Indicate the total amount of cash collected from participants appealing removal or discharge in the box to the right. This amount should not have an associated State Share. All adjustments, refunds and cash collections must be included in the appropriate boxes above.	\$
---	----

I hereby certify that the above information is a correct and complete report of life insurance premiums for all eligible participating employees during the month indicated and paid by the remittance listed. I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the above information is true and correct.

Date	Prepared By	Phone No. ()
------	-------------	------------------